



**COMMUNITY RESOURCE AND REFERRAL FORM
(Primary Care Providers)**

This form enables primary care providers to refer families to early intervention and early childhood special education including other community services/resources (via Help Me Grow/2-1-1) after a developmental screen is administered.

Please complete the form on the second page.

USE THIS GUIDE AFTER A PEDS SCREEN:

AGE OF CHILD	HIGH RISK	MODERATE RISK
Instructions: Please check the box below that best fits and fax to resource.	PEDS Path A, or M-CHAT failed or 3+ unmet milestones on the PEDS:DM	PEDS Path B or C, M-CHAT pass and <3unmet milestones on the PEDS:DM
<input type="checkbox"/> Birth to 3 years	Child Development Watch (North) Call #: (302) 283-7140 Fax# 302-283-7142	2-1-1/Help Me Grow Fax #: (302) 482-4462
<input type="checkbox"/> Birth to 3 years	Child Development Watch (South) Call #: (302) 424-7300 Fax# 302-422-1363/302-424-2916	2-1-1/Help Me Grow Fax #: (302) 482-4462
<input type="checkbox"/> 3 to 8 years	Child Find (See List below)	2-1-1/Help Me Grow Fax #: (302) 482-4462

USE THE INFORMATION BELOW TO REFER TO A CHILD FIND PROGRAM:

Appoquinimink	Kathy Gerstley	302-376-4404/378-5696	Kathy.gerstley@appo.k12.de.us
Brandywine	Joan McNamara	302-479-2600/479-2216	Joan.mcnamara@bsd.k12.de.us
Caesar Rodney	Brook Castillo Adrielle Benini	302-335-5039/335-3705	Brook.castillo@cr.k12.de.us Adrielle.benini@cr.k12.de.us
Cape Henlopen	Susan Berry	302-645-7210	Susan.berry@cape.k12.de.us
Capital	Pam Nichols	302-857-4241/672-1937	Pamela.nichols@capital.k12.de.us
Christina	Dr. Amber Shelton Debra Norton	302-454-2047 302-454-2047 x2	Amber.shelton@christina.k12.de.us Debra.norton@christina.k12.de.us
Colonial	Tammy Wales	302-429-4088/429-4097	Tamara.wales@colonial.k12.de.us
Delaware Early Childhood Center	Dr. Tanya Robinson Tammy Brice	302-398-8945 x101 302-398-8945 x131	tmrobinson@lf.k12.de.us tammy.brice@lf.k12.de.us
Delmar	Christina Fishburn	302-846-9544/846-2793	Christina.fishburn@delmar.k12.de.us
Indian River	Loretta Ewell	302-732-1343/732-1344	Loretta.ewell@IRSD.k12.de.us
Lake Forest	Dawn Troyer	302-284-9611 x123	dltroyer@lf.k12.de.us
Laurel	Zachary Furbay	443-523-0699	Zachary.furbay@laurel.k12.de.us
Milford	Anne Kneipp	302-424-5474	akneipp@msd.k12.de.us
Red Clay	Tina Albanese	302-892-3227	Tina.albanese@redclay.k12.de.us
Seaford	Lisa Doyle	302-629-4587 x2054	Lisa.doyle@seaford.k12.de.us
Smyrna	Carissa Stevens	302-659-6287/653-3146	Carissa.stevens@smyrna.k12.de.us
Woodbridge	Mondaria Batchelor		Mondaria.batchelor@wsd.k12.de.us
Dept of ED (State Coordinator)	Cindy Brown	302-735-4295	Cindy.brown@doe.k12.de.us

This form enables the provider to refer families to the FF :
Child Development Watch
Child Find
Help Me Grow/2-1-1

Are the parents aware you are making a referral? _____

How did you hear about the program? _____

DATE: _____

Child's Name: First _____ Last _____ **Birthdate:** _____ **Medicaid/DHSS Cares#:** _____

Child's Address: _____ (required) **City/State/Zip** _____ **Home Phone #:** _____ (required)

County: _____ **Sex:** Male Female **Child's Ethnicity:** Hispanic or Latino Not Hispanic or Latino

Child's Race (CHECK ALL THAT APPLY): White Black or African American Asian American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander

School District	Primary Language		
Mother's Name (required) MCI#	Birth Date	Email	
Address	Phone #(H)	(CELL)	(W)
Father's Name MCI#	Birth Date	Email	
Address (if different than client's)	Phone #(H)	(CELL)	(W)
<i>Guardian/Foster Parent/Educational Surrogate Name</i>			
Address	Phone #(H)	(CELL)	(W)

Birth Weight	Current Weight	Gestation (weeks)	APGARS
PCP/Office	Phone #	Fax #	
ICD10			

Insurance Information	
Private Insurance Co. Name: _____ Policy Holder: <input type="checkbox"/> Mom <input type="checkbox"/> Dad (MUST include DOB above) Group/Acct # _____ Member ID# _____ Effective Date: _____ Address: _____ Phone # _____	<i>IF DELAWARE MEDICAID ONLY - CHECK BELOW:</i> <input type="checkbox"/> MA-Fee For Service/traditional <input type="checkbox"/> MA-Highmark Health Options <input type="checkbox"/> MA-United Healthcare Notes: _____

Child Care Name	Address	Phone#
------------------------	---------	--------

REFERRING AGENCY/PERSON	Phone #	Email:
<input type="checkbox"/> PEDS Screener	<input type="checkbox"/> ASQ	<input type="checkbox"/> MCHAT
<input type="checkbox"/> Other screening (please specify): _____		

RECEIVING AGENCY ACTION _____

DATE _____

Reason for referral: _____

CDW North: Call: 302-283-7140 Fax: 302-283-7142

Mail - 258 Chapman Rd, Newark, De 19720
 Email - DHSS_DPH_CentralIntake@state.de.us

CDW South: Call: 302-424-7300 Fax: 302-422-1363
 or 302-424-2916

Mail to 18 N. Walnut St, Milford De 19963
 Email with "Referral" in subject to Dhss_DPH_CDW-SHS@state.de.us